RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER
RANCHO RESEARCH INSTITUTE

OCCUPATIONAL THERAPY DRIVER REHABILITATION PROGRAM
CLIENT INFORMATION FORM

Date:_____

Last Name: _____ First Name: _____ Middle Initial: _____

Male☐ Female☐ SSN: _____ Email: _____

Language: English☐ Spanish☐ Korean☐ Other:_____

Cell Phone#:_____ Home Phone#: _____ Rancho#: _____

Address:_____

City:_____ State:_____ Zip Code: _____

Date of Birth: _____ Age:_____ Birthplace:_____
Race:_____

Marital Status: _____ Name of Spouse: _____

Emergency Contact Name:_____ Relationship: _____

Phone #_____

Insurance/Coverage: MediCAL☐ MediCARE☐

Other Insurance: _____

California Children's Services Medical Therapy Unit Name:_____

License status: Never had☐ ID only☐ Permit☐ License☐

Valid☐ Expired☐ Suspended☐ Unknown status☐

License/Permit/ID #:_____ Expiration Date: _____

Referred to the DMV Driver Safety Office: Yes☐ No☐ Unknown☐ Covina☐

El Segundo☐ Commerce☐ Orange☐ Van Nuys☐ Other:_____

Transportation: Driving☐ Family/Friends☐ Bus/Train☐ Metro Access☐

Other:_____ Disabled Person Parking☐

Referral Source: Physician☐ Therapist☐ DMV☐ Family☐ Self☐

Friend☐ Brochure☐ Other: _____

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